Application to:
PFL LIFE INSURANCE COMPANY

BAPP

Life Insurance

FOR HOME OFFICE USE ONLY
Number

Special Request

PLAN OF INSURANCE: Term
PREMIUM AMOUNT

FACE AMT. / SPEC AMT.
☒ Level 1 ☐ Level 2

Soc. Security # (Applicant) 2367

BENEFITS
☐ ADD ☐ ADB
☐ ☐

DIVIDEND OPTION
☐ Accumulate at Interest (Automatic Option)
☐ Paid in Cash
☐ Paid up Additions

OWNERSHIP (Life Insurance Only)
(COMPLETE ONLY IF OTHER THAN PRIMARY APPLICANT)
A. OWNERS NAME
B. ADDRESS
C. CITY, STATE, ZIP
D. OWNER'S SOCIAL SECURITY NO.
E. OWNER'S DATE OF BIRTH MO ____ DAY ____ YR ____
AUTOMATIC PREMIUM LOAN (If available) ☐ YES ☐ NO

Health Insurance

PMH Deductible
☐ $ 250
☐ $ 500
☐ $ 750
☐ $ 1,000
☐ $ 1,250
☐ $ 1,500
☐ $ 1,750
☐ $ 2,000
☐ $ 2,500
☐ $ 5,000

Health Insurance Applied For:

GHP6 MAX BENEFIT
☐ $500,000
Ded. $ ____

DAILY BENEFIT
☐ $150 ☐ $200
☐ $250 ☐ $300
☐ $350 ☐ $400
☐ $ ____
Ded. $ ____
☐ GHP7 ☐ GHP5

GHP8
☐ 100%
☐ 80/20
☐ 50/50
☐ ____
Ded. ☐ $600
☐ $1,200
☐ $2,400
☐ $____

☒ PPO ☐ EPO
PPO Copay Options
☒ 10 ☒ A
☐ 15 ☐ B
☐ 20 ☐ C
☐ 25 ☐ D

☒ Rx
☐ Vision
☐ Other

Social Security # (Applicant) 2362

OTHER COVERAGE (if any)

	Amount	Add'l Premium
☒ Accident Benefit	$ 6,000	$ Inc
☐ Childbirth Benefit	$ ____	$ ____
☒ OP Chemo. Benefit		$ Inc
☐ Ret. of Prem. Ben.		$ ____
☒ Test./Therapy Ben.	10/6000	$ Inc
☐ Outpatient Care Opt.(Ded)	$ ____	$ ____
☐ Cat. Expense Ben. (Ded.)	$ ____	$ ____
☐ Accident Waiver Ben.		$ ____
☐ Double Misc. Ben.	$ ____	$ ____
☐ Triple Misc. Ben.	$ ____	$ ____
☐ Double Surg. Ben.	$ ____	$ ____
☐ Triple Surg. Ben.	$ ____	$ ____
☐ Life Ins. Benefit Rider	$ ____	$ ____
☐ Prescription Drug Rider		$ ____
☐ Other	$ ____	$ ____
Total Additional Premium		$ ____

Dental Insurance

☒ YES ☐ NO
If applying for Dental Insurance, is any Proposed Insured person in the full-time service in the armed forces (other than for training for a period not to exceed 60 days)?
☐ YES ☐ NO
If yes, list name(s)

Soc. Security # (Applicant) 2367

Disability Income Insurance

☐ Disability Income
Amount $ ____
Elimination Period ____
Benefit Period ____
Occ. Class ____

Soc. Security # (Applicant)

Other Coverage (if any)

		Add'l. Prem.
☐ AD & D	____	$ ____
☐ Return of Premium	____	$ ____
☐ Hospital Conf.	____	$ ____
☐ Business Overhead	____	$ ____
Mo. Max.	$ ____	
Elim. Prd.	$ ____	
☐ Other	____	$ ____
Total Add'l. Premium	____	$ ____

Accident Insurance

DAILY BENEFIT-GACC7
☐ $150 ☐ $200
☐ $250 ☐ $300
☐ $350 ☐ $400
☐ $ ____
Ded. $ ____

GACC8
☐ 100%
☐ 80/20
☐ 50/50
☐ ____
Ded. ☐ $600
☐ $ ____
☐ $2,400
☐ $ ____

Social Security # (Applicant)

OTHER COVERAGE (if any)

	Amount	Add'l Premium
☐ Accident Benefit	$ ____	$ ____
☐ Double Misc. Ben.	$ ____	$ ____
☐ Triple Misc. Ben.	$ ____	$ ____
☐ Double Surg. Ben.	$ ____	$ ____
☐ Triple Surg. Ben.	$ ____	$ ____
☐ Spc. Dis. & Emerg. Med. Care Benefit	$ ____	$ ____
☐ Acc. & Spc. Dis. OP Therapy Benefit	$ ____	$ ____
☐ Other	$ ____	$ ____
Total Additional Premium	$ ____	$ ____

BENEFICIARY
PRIMARY Troy M. Tillerson
RELATIONSHIP Father
SOCIAL SECURITY # [redacted] 8965

CONTINGENT Carol J. Owens
RELATIONSHIP Mother
SOCIAL SECURITY #

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Exhibit B

TI000059

SECTION A — COMPLETE THIS SECTION FOR ALL APPLICATIONS

1. *PRINT* name of applicant and each member of the family (including wife's maiden name)	Relationship	State of Birth	Sex	Date of Birth Mo.	Day	Yr.	Present Age	Height	Weight How	1 Yr. Ago	Premium
(1) Troy E. Tillerson	Applicant	AL	M	[redacted]		64	32	6'	235	235	
(2)	Spouse										
(3)											
(4)											
(5)											
(6)											

Pay mode: Monthly ☒ Quarterly ☐ Semi-Annually ☐ Annual ☐ Total Premium ____

Insurance applied for: Life = L Health = H Dental = Den Disability Income = Dis Accident = A Rx Drug = Rx Vision = V

Member # (1) Applicant H, L, Rx, D (2) Spouse ____ (3) ____ (4) ____ (5) ____ (6) ____

2. Addresses: Number and Street or R.F.D. City State Zip Telephone

☐ a. Permanent U.S. Residence [redacted] Deatsville 36022 (334) 285 ...

b. Business Name Alabama Home Inspection

☐ c. Business Address Same

3. a. Primary Occupation: (Member 01) Home Inspector

b. Duties (describe in detail): Inspects Homes

c. List any other occupations, second jobs or part-time jobs and your duties: ____

SECTION B — COMPLETE THIS SECTION FOR HEALTH, LIFE, DISABILITY INCOME AND ACCIDENT

	Yes	No
4. I am a member of the National Association for the Self Employed	☒	☐
5. Are any family members covered under Medicaid or Medicare? Name(s) ____	☐	☒
6. Has any person proposed for insurance: a. Ever had an application or reinstatement for life, disability income or accident and sickness insurance declined, postponed, rated up, modified, or terminated?	☐	☒
b. Had a drivers license suspended or revoked in the last two years? Give details if any question is answered "Yes": ____	☐	☒
7. Are all children or stepchildren of the Applicant proposed for insurance by this Application, currently unmarried and under the age of nineteen (19) years and residing at the Applicant's principal place of residence; or under the age of twenty-four (24) years and enrolled as a full-time student at an accredited college or university? If answer is "No," give name(s) and reason: ____	☐	☒
8. During the past two years, has any person proposed for insurance: Flown in any aircraft other than as a passenger, engaged in any racing, parachuting, scuba diving activities, or other hazardous avocations or does he/she intend to do so in the next 12 months? If "Yes," give details: Scuba Diving - for 9 yrs Stays above 1 Atmosphere	☒	☐

SECTION C — COMPLETE THIS SECTION FOR HEALTH, LIFE AND DISABILITY INCOME

9. Family Physician/Physician who would have medical records.

a. For Applicant: Name Dr Mark Hayden Address 26297 Tallassee Hwy

City Wetumpka State AL Zip 36092 Telephone No: (334) 514 ...

Date last seen 1996 Reason Cold

b. For Spouse: Name ____ Address ____

City ____ State ____ Zip ____ Telephone No: ( ) ____

Date last seen ____ Reason ____

c. For Children: Name ____ Address ____

City ____ State ____ Zip ____ Telephone No: ( ) ____

Date last seen ____ Reason ____

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SECTION C CONT'D. COMPLETE THIS SECTION FOR HEALTH, LIFE, AND DISABILITY INCOME

Question	Yes	No
10. Within the past 5 YEARS has any person proposed for insurance:		
a. Had or been advised to have a surgical operation, electrocardiogram, x-ray or other diagnostic test?	☐	☑
b. Been in or advised to enter a hospital or other institution for consultation, examination or treatment?	☐	☑
c. Consulted or been examined by any physician or other practitioner?	☑	☐
d. Used sedatives, hallucinogenic or narcotic drugs other than those prescribed by a physician or received treatment for a drug habit?	☐	☑
e. Received treatment or advice for excessive use of alcohol?	☐	☑
11. Is any family member now pregnant?	☐	☑
12. Has any person proposed for insurance used any tobacco products within the past 12 months?	☑	☐
13. Has any person proposed for insurance ever been rejected or deferred for military service?	☐	☑
14. Is any proposed insured presently under observation or taking treatment?	☐	☑
15. Has any person proposed for insurance EVER had any indication, diagnosis, or treatment of:		
a. The brain or nervous system, including but not limited to dizziness, fainting, migraines, convulsions, paralysis, stroke, mental or nervous disorder?	☐	☑
b. The respiratory system, including but not limited to shortness of breath, persistent hoarseness or cough, bronchitis, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	☐	☑
c. The heart or blood vessels, including but not limited to chest pain, blood pressure, rheumatic fever, heart murmur, heart attack, varicose veins, or other disorder of the heart or blood vessels?	☐	☑
d. The gastro-intestinal tract, liver or pancreas, including but not limited to jaundice, intestinal bleeding, ulcer, colitis, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☑
e. The genito-urinary organs, including but not limited to sugar, albumin, blood or pus in urine, stone or other disorder of kidney, urinary bladder, or prostate?	☐	☑
f. The eyes, ears, nose or throat?	☐	☑
g. Diabetes or elevated blood sugar, thyroid or other glandular disorder, including but not limited to lymph glands?	☐	☑
h. Neuritis, arthritis, gout, disorder of the muscles or bones, including but not limited to spine, back, or joints?	☐	☑
i. Complications of pregnancy and/or cesarean section?	☐	☑
j. Deformity, lameness or amputation?	☐	☑
k. Cyst, tumor, cancer, or growth of any kind?	☐	☑
l. Allergies, anemia or other disorders of the blood?	☐	☑
m. Disease or disorder of the reproductive organs or breasts?	☐	☑
16. Has any person proposed for insurance EVER been diagnosed or treated for any disorder or dysfunction of the blood system or immune system including but not limited to Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or Lymphadenopathy Syndrome?	☐	☑

COMPLETE THE FOLLOWING FOR ANY "YES" ANSWER TO QUESTIONS 10 THRU 16

Ques. No.	Person No.	Nature of Injury, Sickness, Disease, Impairment or Physical Condition	Date	Hospitalization Required?			Surgery Performed?			Name and Address of Physician and Hospital
				Yes	No	Date	Yes	No	Date	
14c	1	[illegible] Complete Recovery	1996		✓			✓		Dr. Hayden

17a. List below all life, health and disability income insurance currently in force or that you have applied for in the last six months. If none, state none.

#	COMPANY NAME	TYPE of COVERAGE	LIFE INS. AMOUNT	DISABILITY BENEFIT AMOUNT	DISABILITY BENEFIT PERIOD	DISABILITY ELIM. PERIOD	Status: Applied for	Status: In Force Standard	Status: In Force Substandard
1	None						☐	☐	☐
2							☐	☐	☐
3							☐	☐	☐
4							☐	☐	☐
5							☐	☐	☐

b. Which of the above will be changed, terminated, not taken, or replaced by coverage(s) that you are applying for on this application. ☐ If None, check here.

FROM 17.a	DATE OF CHANGE OR TERMINATION	DETAILS-IF CHANGE

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SECTION D — COMPLETE THIS SECTION FOR LIFE AND DISABILITY INCOME

18. Annual earned income from personal services (after business expenses, if any) as you reported on your Federal Income Tax Return:

	Last Year	Current Year (est.)
Salary, Draw, Professional Fees	$	$
Other (describe):	$	$
TOTAL	$	$

19. List your unearned income from investments or other sources (e. g., dividends, interest, net rental income, pensions, alimony, etc.):

Last Year	Current Year (est.)
$	$

SECTION E — COMPLETE THIS SECTION IF APPLYING FOR BUSINESS OVERHEAD EXPENSE RIDER

20. a. What is the Applicant's share of the overhead expenses? _____ %

b. List below the total monthly expenses of the business entity for which you are liable:

Rent/Mortgage Payment $_____ Vehicle, Machinery, Equipment Rental $_____ Interest on Business Loans $_____

Utilities (Electricity Telephone, Heat) $_____ P & C Insurance $_____ Employees Salaries (other than family) $_____

Ad Valorem Taxes on Business Equipment Property $_____

TOTAL COVERED $_____
Other Expenses $_____
TOTAL EXPENSES $_____

21. a. How many people are employed by this company? (Include the Applicant in the total)

Owners: Full-time _____ Part-time _____
Employees: Full-time _____ Part-time _____

b. Do any of the above include spouse, parent, son, daughter, brothers or sisters of you or your spouse? ..... ☐ Yes ☐ No

If yes, indicate number of Owners _____ Employees _____

22. The Applicant's company is a: ☐ Sole Proprietor ☐ Partnership ☐ Corporation
☐ S Corporation-Date of Election ___ / ___ / ___ (Mo. / Day / Yr.) ☐ Other (Specify) _____

SECTION F — COMPLETE THESE TWO QUESTIONS IF CHILD LIFE INSURANCE IS APPLIED FOR

1. If the Proposed Insured is under age 15, list age of brothers and sisters and amount of insurance on each of their lives: (Attach additional page with information)

2. How much life insurance is carried by:
(a) Father _____ (b) Mother _____
(c) If this application is greater than (a) or (b) above: (Attach additional page with explanation)

TRUE AND COMPLETE

I understand each of the questions above and affirm that the recorded answers and statements are true and complete to the best of my knowledge and belief, and all information given to the agent has been recorded correctly and in its entirety.

_____
Signature of Applicant

DECLARATION AND AGREEMENTS

I agree that: (a) this Application will form a part of the contract; (b) the agent does not have the authority on behalf of the Company to accept risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage; and (c) no insurance will take effect unless and until the Application is approved by the Company and the policy/certificate is delivered to the Applicant while the conditions affecting insurability are and have remained as described herein and the first premium has been paid in full. I understand any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is subject to criminal and/or civil penalties. I hereby acknowledge receipt of a copy of the Fair Credit Reporting Act and Medical Information Bureau notices.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any record or knowledge of me or my family, to give PFL Life Insurance Company, or its reinsurers, any such information. PFL Life Insurance Company may also release information about me to its reinsurer. I authorize PFL Life Insurance Company to obtain an investigative consumer report on me. A photographic copy of this authorization shall be as valid as the original.

I have truly and accurately recorded the information as supplied by Applicant and family members.

_____
Signature of Licensed Agent

A289
_____
Agent's Number

$ 75.00
_____
Amount Collected By Agent

I UNDERSTAND THAT COVERAGE IS NOT EFFECTIVE UNLESS AND UNTIL APPROVED AND ISSUED BY THE COMPANY

Dated at Dothan AL 1-9 19 96
City State Month Date Year

Signed X _____ I [redacted] 2367
Applicant (For and in behalf of above) Social Security #

Signed X _____ I _____
Spouse Social Security #

(900-AG (794) **CHECK MUST ACCOMPANY APPLICATION**

TI000062